Waiver 5 0208 Home and Community Based-Services (ages 0-15)
Freedom of Choice and Consent Form effective 7/1/2013

Child's Name: SSN: DOB:

The DDP Waiver 5 Freedom of Choice Form is used to ensure that all Developmental Disabilities Program waiver participants understand their right to:

1. Choice of waiver services, including self-direction
2. Choice of providers of DDP funded services
3. Choice of filing a fair hearing request
4. Choice between waiver services and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)*

_____I have been informed of services available to my child through the Medicaid Home and Community-Based Services Waiver Program. The choice of service provider and choice of services are available to all persons in DDP-funded services subject to demonstration of assessed need.

_____I have been informed of the conditions under which I may choose to self-direct my child's waiver services.

_____I have been informed that if my child's assessed needs cannot be adequately and safely met in the community, he/she will not be offered DDP-funded services. I have also been informed that if while in DDP-funded services my child's condition deteriorates to the point that he/she cannot be maintained safely in the community, my child could be at increased risk of future placement in an ICF/IID.*

_____I have been informed of services available in an ICF/IID facility, including the judicial process involved in the placement of persons in an ICF/IID facility.*

_____I have been informed that I have the right to request a Montana Department of Justice criminal back ground check at no personal cost to me for any person providing my child with services not under contract with the DDP. I understand that employees of agencies under contract with the DDP are required to have background checks.

_____I have been informed of the State of Montana fair hearing process if my child is denied the service(s) of choice or the provider(s) of choice.

* In Montana ICF/IID services are not available to persons under 18 years of age.

After reviewing my options and choices, I freely choose to (*check all that apply*):

☐ Receive services in the community via the HCBS DD Medicaid Waiver.

☐ Receive services from my existing provider(s). _____

☐ Receive services from a different provider (specify). _____

☐ Self direct allowable waiver services.

☐ Not receive DDP-funded waiver services at this time.

Participant/Guardian or Personal Representative Date

Targeted CM or Waiver Children's Case Manager (WCCM) Date

Department Representative – for initial 0208 Waiver 5 Date

Revised 7/1/2013